Special Needs Plan Legislation

Position Paper
Volume 1, Issue 4

MMA Report language indicated that Congress wanted SNPs "to develop targeted clinical programs to more effectively care for high-risk beneficiaries."

Special Needs Beneficiaries were defined as beneficiaries who are:

- *Institutionalized*
- *Dually eligible for Medicare and Medicaid*
- *Persons with severe or disabling chronic conditions*

SNPs that specialize in care of beneficiaries who are already frail, disabled, and/or with co-morbid or late-stage chronic conditions are dependent on payment methods, oversight structures and evaluation measures that recognize the added risk and complications of concentrating on care of high-risk beneficiaries.

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Special Needs Beneficiaries Require Special Health Policy

In 2003, Congress established Medicare Advantage Special Needs Plans (SNPs) to improve cost and quality outcomes for high risk enrollees by:

- *Authorizing plans to target enrollment to special needs beneficiaries.*
- *Stimulating specialty care interventions for high-risk beneficiaries.*
- *Transitioning specialty demonstrations to permanent status.*
- *Establishing a platform for integrating Medicare and Medicaid.*

Frail elders, adults with disabilities and other persons with complex needs are the highest-cost and fastest growing service group. Long-term cost and quality objectives cannot be achieved without SNPs and policymakers both changing their behaviors. SNPs must show how they are special, but SNPs cannot significantly alter clinical practice and outcomes unless payment methods, oversight structures and evaluation methods—the fundamental forces that drive market behavior— also change.

Improving cost and quality performance requires focusing on the underlying problem-- an ineffective system of care for the highest-risk beneficiaries. SNPs are *required* to target high-risk beneficiaries. Early indications are that specialty programs for this population show great potential to improve cost and quality outcomes; e.g. reducing inpatient, emergency room and long-term nursing home use. More time is needed to demonstrate SNP effectiveness on a broader scale. Last year, CMS revised SNP application requirements to continue advancing SNP specialization for frail, disabled and chronically ill persons. Congress also can take additional steps to strengthen and further advance SNP specialization, as outlined below.

Congress Should Extend SNP Authority for 3 Years and Establish Policy Key to SNP Success

In January of 2007, there were over 470 SNPs serving nearly 1 million enrollees. SNP statutory authority expires December 31, 2008. Most SNPs are new and in the early stages of implementing interventions that will take time to test. The pending Report to Congress will not be able to offer definitive findings on cost and quality. The Report will be based primarily on one year of profile information since the study period is limited to 2006, standard quality data are not yet available and CMS has limited access to cost data. Congress should extend SNP authority for three years, sharpen its expectations of SNPs, require CMS to modify payment consistent with SNP targeting requirements and authorize CMS to change administrative and oversight rules to be more in keeping with the special care requirements of special needs beneficiaries.

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Specialized managed care cannot survive using standard payment methods, oversight structures, and performance measures.

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A Foundation for Specialty Care

To improve total quality and cost performance **Congress should**:

Establish New Definitional Requirements

After one year of operation a Chronic Condition SNP should serve no less than 75% of special needs individuals it seeks to target for special enrollment. After two years of operation a Chronic Condition SNP should have an average risk score of no less than 1.1 for the plan to maintain Special Needs Plan status.

Require Complex Care Management for SNPs

SNP care management services should not be limited solely to standard utilization management or singular disease management telephonic care management strategies. The specialized methods should be tailored to the needs of special needs individuals and include the following elements:

- Assessment of health and functional needs of the individual;
- Development of a plan of care that defines goals and objectives;
- Application of protocols for achieving desired objectives and outcomes;
- Assignment of appropriate clinical staff to meet health care needs;
- Coordination of clinical staff and other service providers involved;
- Periodic reassessment of individuals' health care needs and modification of care plans to reflect changing conditions;
- Periodic measurement of the effectiveness of plans of care.

Require SNPs to Report on Specialty Care

Congress should require SNPs to report on care management in promoting: (1) continuity of care, (2) safe and effective care transitions, (3) functional independence, (4) member choice, (5) medication management, (6) co-morbidity management, (7) mental illness and behavior health, and (8) family caregiver support. Congress also should require SNPs to report on reduction of avoidable hospitalizations and outcomes for other services, with emphasis on inpatient and outpatient hospital services for ambulatory care sensitive chronic conditions and long-term nursing home placement.

Align Payment Incentives with Specialization

Congress should require CMS to modify risk adjustment payment methods to adequately account for the added cost burden for SNPs that enroll a significant proportion of high-cost/high-risk beneficiaries, with changes implemented no later than for contract year 2010.

Incentives for Pay-for-Performance

Congress should require CMS to set aside one-fourth of the CMS designated MA savings to pay SNPs that meet or exceed certain quality measures and up to one-fourth of such savings for states that integrate Medicare and Medicaid.

Advance Medicare/Medicaid Integration

Congress should require CMS to establish an office on Medicare/Medicaid Integration to align Medicare and Medicaid rules, oversight and financing.

About The SNP Alliance…

The SNP Alliance is an alliance of special needs plans that include all SNP models and all legacy demonstrations that have built the foundation for specialty care. Members are committed to keeping the bar high for SNPs by targeting high-risk beneficiaries, promoting innovation in care of frail, disabled, medically complex and dually eligible individuals and committing to SNP Alliance quality standards.

Medicare/Medicaid Integration

Position Paper
Volume 1, Issue 2

Approximately 42% of Medicaid funds and 28% of Medicare are spent on care of persons dually eligible for both programs. Centers for Medicare and Medicaid Services

20 percent of people 65 and older have five or more chronic conditions and account for 68 percent of Medicare spending. Partnership for Solutions

Four-fifths (82 percent) of projected Medicaid expenditure growth reflects increases in the cost of caring for aged, blind and disabled Medicaid beneficiaries. Center on Budget and Policy Priorities

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Fragmented Policy Fragmented Care

The Medicare Modernization Act of 2003 (Section 231) established a new category of MA plans called Special Needs Plans (SNPs). For the first time in history, Congress authorized the targeted use of flexible, capitated financing to re-engineer healthcare to better serve Medicare beneficiaries with special care needs. This included an opportunity to realign how care is provided to the 7 million beneficiaries who are dually eligible for Medicare AND Medicaid programs. Of the 476 Special Needs Plans awarded 2007 contracts, 321 *target* persons who are dually eligible for Medicare and Medicaid. In addition, most Institutional SNPs serve a high percentage of dually eligible beneficiaries.

While SNPs provide an important platform for improving care for this common subset of Medicare and Medicaid beneficiaries, Congress did not require that CMS and States realign Medicare and Medicaid financing, policy and oversight or eliminate duplications and inconsistencies that cause significant and unnecessary confusion, medical complications and waste. It also did not require Dual SNPs to provide Medicaid benefits or coordinate benefits and services between the two programs. It left in place a complex web of rules and regulations that result in a fragmented, silo-based approach to care in serving millions of frail elders, adults with disabilities and other persons with complex medical and social needs.

Each year, our federal government spends over $200 billion dollars in care of over 7 million dual beneficiaries, yet no person or unit within CMS has full time responsibility to monitor and resolve inconsistencies in Medicare and Medicaid or align program financing and oversight policy. Key staff within CMS have provided important leadership in advancing integration, but the work of integration has only just begun.

Devastating Effects on High-Risk Beneficiaries

While Medicare and Medicaid remain separate federal programs, both programs support a common and growing number of frail elders, adults with disabilities and persons with severe or disabling chronic conditions. Under our current fragmented system, most dual beneficiaries must access care through different plans and multiple providers who work under different and frequently conflicting regulations, oversight structures and financial incentives. This is true under fee-for-service and capitated financing. The resulting incentive is for plans and providers to work within the framework of their own business structure, without regard for the adverse effects this has on serving a common high-risk population. People with complex care needs have difficulty in accessing appropriate services. Costly errors often are made in transitions between care settings. Providers unknowingly provide conflicting clinical interventions and people are unnecessarily hospitalized or placed in nursing homes. Errors abound with little documentation.

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Toward an Ideal Model of Care

Frail elders, adults with disabilities and other persons with complex care needs represent the largest and fastest-growing segment of Medicare and Medicaid costs. Many beneficiaries served by all SNP types (i.e. dual, institutional, and chronic condition SNPs) are eligible for Medicare *and* Medicaid benefits and require a full array of primary, acute and long-term care services. The SNP Alliance recommends that CMS, States and SNPs work toward establishing methods of integration that ultimately allow:

- Dually eligible beneficiaries to receive ALL their Medicare and Medicaid benefits through a single Integrated Special Needs Plan.
- Frail elders, adults with disabilities and other complex care beneficiaries to receive services from specialty networks of primary, acute and long-term care providers that work together to optimize total cost and quality performance.
- Integrated SNP beneficiaries to receive one set of marketing and enrollment materials and use one process for grievance and appeals.
- Integrated SNPs fully at risk for all Medicare *and* Medicaid benefits to receive risk-adjusted payments that fully account for their added risk burden, and to pool funds to optimize total quality and cost performance.
- Integrated SNPs to submit one application for Medicare and Medicaid benefits and CMS and States to use an integrated approach to monitor performance.
- Evaluations of SNP performance using measures and methods that recognize the multidimensional, interdependent and ongoing nature of care as the needs of beneficiaries evolve over time and across care settings.

Critical Next Steps

To improve *total* quality and cost performance in serving dual beneficiaries:

***CONGRESS should**:*

- Direct CMS to establish an Office on Medicare/Medicaid Integration Policy, accountable to the Administrator, to integrate Medicare and Medicaid administrative and oversight rules and align financial incentives with goals to:
    - Simplify access to Medicare and Medicaid benefits
    - Improve care continuity among related providers
    - Eliminate inappropriate cost shifting
    - Eliminate regulatory conflicts
    - Improve total quality and cost performance
- Authorize CMS to align Medicare and Medicaid rules as needed to advance the integration of Medicare and Medicaid benefits, administration and care.
- Share 25% of MA savings returned to CMS with states as an incentive to align Medicare and Medicaid financing and improve quality and cost performance.

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We tend to focus on snapshots of isolated parts of the system and wonder why our deepest problems never seem to get solved."
-Peter Senge

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Improving SNP Performance

Position Paper
Volume 1, Issue 3

Need New Pathway To Measuring SNP Performance

The Medicare Modernization Act of 2003 (Section 231) established a new category of MA plans called Special Needs Plans (SNPs). SNPs are required to target enrollment of special needs beneficiaries. CMS is required to submit a Report to Congress by the end of this year regarding SNP impact on cost and quality.

Current performance measures and methods do not account for the multi-dimensional, interdependent, and ongoing nature of care for persons with complex chronic conditions.

As of January 1, 2007, over 200 of the 476 SNPs were new to the marketplace. In 2006, the year of program evaluation, most SNPs were only beginning to enroll special needs beneficiaries. New specialty care interventions were just beginning to be established with many cost-saving interventions not expected to produce results for several years. Further, since MA plans are not required to submit claims data directly to CMS, data are not readily available for comparing SNP utilization patterns with fee-for-service beneficiaries or other MA plans.

Older adults suffer from a multitude of conditions and are especially susceptible to effects of poor care; yet we know relatively little about the quality of health care older people receive.
Rand Health

Research by Rand, Hopkins and noted geriatricians underscores the need for measures that account for the multi-dimensional and ongoing nature of chronic disease, frailty and disability. Existing measures focus primarily on provider-specific interventions at a specific point in time, without regard for the interdependence among related interventions and provider behaviors or cumulative effects over time. Congress did not require CMS to establish new performance standards or specialty care measures that account for the unique aspects of serving persons with complex chronic conditions. CMS acknowledges the need for such measures, however, and recently engaged the National Committee on Quality Assurance to develop new SNP performance indicators. While these measures are not likely to be fully implemented, tested and producing measurable data for several years, SNPs can begin reporting on them sooner rather than later.

Too Early To Prove Impact on Cost and Quality

The 2007 Report to Congress on SNP cost and quality will be limited primarily to descriptive data offering SNP profile information. Quantitative data, such as HEDIS and HOS scores, will not be available for the 2006 study period and only one year of bid data will be used. Legacy plans show great promise for improving performance in care of high-risk beneficiaries, such as reducing hospital and nursing home use. More time is needed to develop appropriate performance measures and study outcomes to draw definitive conclusions about SNPs. In the interim, Congress could require SNPs to begin reporting on peer reviewed process measures that medical specialists and researchers conclude will contribute to positive outcomes.

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CMS is unlikely to be able to tell Congress how well Special Needs Plans are able to serve a high-risk population anytime soon.

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To Advance Quality Performance

***CONGRESS should**:*

- Require Special Needs Plans to establish specialized care management methods appropriate to the needs of special needs individuals.
- Require SNPs to report on inpatient hospital and emergency room services for ambulatory care sensitive conditions and long-term nursing home placement, or other services covered under Titles XVIII and XIX.
- Set aside 25% of MA savings returned to CMS to reward plans for quality improvements based on criteria consistent with the process measures below.

CMS should:

- On an interim basis, streamline reporting of HEDIS measures to those appropriate for persons with ongoing, complex care needs and work with States to align and integrate Medicare and Medicaid reporting requirements.

Process Measures to Monitor SNP Performance

Congress should direct SNPs to report the effectiveness of care management in promoting:

- **Continuity of care**: To ensure coherent, consistent and connected collective performance among patients and family caregivers and primary, acute and long-term care providers in addressing the needs and interests of individuals as their conditions evolve over time and across care settings.
- **Safe and effective care transitions**: To ensure that people move safely and easily from one care setting to another, from one level of care to another, and/or from one health care practitioner to another.
- **Functional independence**: To optimize the ability to perform self-care, self-maintenance and physical activity, including addressing issues of disability, impairment, and/or frailty.
- **Member choice and quality**: To ensure consumer satisfaction as measured by consumer defined goals.
- **Medication management:** To optimize compliance and drug performance and minimize adverse drug events, with special focus on poly-pharmacy issues.
- **Population specific medical conditions**: To effectively manage falls, incontinence, dementia/delirium, incontinence, pain, pressure ulcers, osteoporosis, and other syndromes unique to special needs beneficiaries.
- **Management of multiple and/or co-morbid conditions:** To advance a multidimensional, integrated approach to medical and health care management, including special tools and the integration and adaptation of disease-specific guidelines that address the interactive effects of multiple chronic conditions and associated health-related challenges of serving people with serious chronic conditions.
- **Mental illness/behavioral management**: To optimize a person's health and well being, with recognition of chronic depression, Alzheimer's disease, schizophrenia, AODA and other mental illnesses as a primary and/or as a co-morbid condition in addressing other acute and/or chronic conditions.
- **Family caregiver support:** To recognize the critical role of family caregivers as part of the care team, integrate their support into member care planning and provide support and education that enhances their effectiveness as part of the care team.

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MA Payment impact on SNPs

Position Paper
Volume 1, Issue 1

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Plan level risk scores for some Special Needs Plans are two to three times the national average for Medicare Advantage plans. Other plans report four times as many beneficiaries with 6 or more chronic conditions as the average MA Plan.

SNP ability to specialize in care of high-cost/high-risk beneficiaries is dependent on payment methods that recognize the added risk burden of targeting beneficiaries who are already frail, disabled, and/or with co-morbid or late-stage chronic conditions.

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Current Payment Methods Needs Refinement for Specialty Care

The Medicare Advantage (MA) payment system adjusts payments based on an enrollee's health status. The "CMS-HCC" risk adjustment method is based on 70 diagnostic categories. Some conditions like diabetes have multiple risk scores to differentiate payment in relation to condition complexity. Others, such as congestive heart failure, have only one payment rate, regardless of medical complexity. The MA payment method also adjusts for health risk for dual eligibility and pharmacy costs.

Historically, CMS provided an additional interim frailty adjuster to payment for selected MA demonstrations and the Program of All Inclusive Care for the Elderly (PACE). The CMS-HCC payment method more accurately predicts risk for high-cost beneficiaries than the old demographic model, but continues to underpay for the highest-cost beneficiaries and for frailty. Accordingly to Pope et al, the new method will continue to underpay the highest-cost beneficiaries (top 20%), in relation to fee-for-service, by about 14% and by about 18% for persons with 3 or more annual hospitalizations. It will continue to overpay the lowest-cost beneficiaries (bottom 20%) by approximately 23%, creating a disincentive to target high-cost enrollees.

The HCC payment works well for plans serving an average distribution of Medicare beneficiaries and penalizes plans that disproportionately serve high-cost beneficiaries. Payment equity is critical for plans that exclusively focus on improving total quality and cost performance for high-risk groups.

No Plan or Timetable to Correct for Known Deficiencies in Paying SNP Targeting High-risk

In 2004, CMS added an interim adjustment to MA payment for PACE and selected demonstrations that specialize in high-risk care to account for MA's underpayment for frailty. In February 2007, CMS announced plans to modify the frailty adjuster for PACE, based on new cost information, and transition all demonstrations to a standard MA payment method. CMS indicated it would continue to explore payment options to account for frailty, but did not identify a plan or timetable to correct known deficiencies in paying plans that target high-cost/high-risk beneficiaries. This will not have an adverse effect on most MA plans, as most MA plans' illness profile is similar to the general Medicare fee-for-service population. The failure of Medicare to compensate plans for the added risk burden of targeting rather than avoiding high-risk/high-cost groups could preclude the ability of SNPs to exclusively serve high-risk beneficiaries, especially when combined with phase-out of budget neutrality factors, fee-for-service normalization, and proposed cuts in MA payment.

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Ensure Fair and Equitable Payment

SNP authority has enabled national demonstrations specializing in high-risk care to transition to permanent plan status. It also authorized other managed care organizations to establish plans that exclusively or disproportionately enroll high-risk Medicare beneficiaries and offer specialty care interventions. Congressional intent to use the power of managed care for advancing care of high-cost/high-risk beneficiaries will not be fulfilled unless SNPs that exclusively or disproportionately specialize in high-risk care are appropriately compensated for their added risk burden.

PACE illustrates the power of aligning financial incentives with policy goals. Allowing PACE programs to pool and flexibly allocate risk adjusted Medicare payments with a Medicaid capitation set close to institutional payment rates led to advancing specialty care for nursing home certifiable beneficiaries living in the community. SNPs should be offered a comparable opportunity to further advance specialty care, expand consumer choice, and ensure fair treatment of SNPs serving a comparable high-risk population.

Congress is considering differential treatment among MA plan types based on extra benefits offered, degree of efficiency and added value, and costs as a percentage of FFS payments. CBO stratified MA payment levels as a percentage of different FFS costs, recognizing challenges of an across the board reduction to FFS levels. Congress should account not only for MA underpayment for high-cost enrollees, but also consider the added value achieved by improving payment for SNPs targeting high-risk populations.

Critical Next Steps

Congress established Special Needs Plans to enable MA plans to specialize in care of persons with multiple, complex and ongoing care needs. The long-term success of SNPs targeting high-risk populations is dependent on refinement of risk-adjusted payment methods for Special Needs Plans.

***CONGRESS should**:*

- Require CMS to refine Medicare Advantage risk adjustment methodologies to adequately account for the added risk burden for SNPs that enroll a significant proportion of high-cost/high-risk beneficiaries.

***CMS should**:*

- Take into account pharmacy costs, institutional costs, and cost associated with comorbidity, frailty, disability, late stage conditions, dual eligibility and other such factors as the Secretary may deem appropriate.
- Modify payment methods to account for the added risk burden of plans that enroll high-risk beneficiaries with no prior Medicare history but with a known chronic condition e.g. AIDS.
- Implement such changes no later than for contract year 2010.

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